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Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

Bureau of Medical Services

October 21, 2004

TO: Interested Parties

FROM: Christine Gianopoulos, Acting Director, Bureau of Medical Services

SUBJECT: Final Rule: MaineCare Benefits Manual, Chapters II & III, Section 22, Home and Community Benefits for the Physically Disabled

The adopted rules specify the case management and administrative roles of the provider agency. The adopted rule also clarifies when services are considered to be duplicative, covered services, definitions, and the eligibility process. Certain information, such as confidentiality requirements, that is already included in Chapter I, is deleted. Terminology, such as using MaineCare instead of Medicaid and member instead of recipient, is also updated.

Chapter III establishes new billing procedure codes based on HIPAA compliant CPT coding. Chapter III also implements a change in reimbursement to the Provider Care/Management Agency.

Although not specifically reflected in this rule, management of this benefit has been transferred by the Maine State legislature from the Department of Labor to the Bureau of Elder and Adult Services, Department of Health and Human Services. In addition, an independent Assessing Services Agency will be used for member assessments.

A public hearing was held on September 3, 2004. Written comments were received on the proposed rule until September 14, 2004. This rule will be effective for services provided on or after October 31, 2004.

Rules and related rulemaking documents may be reviewed at and printed from the Bureau of Medical Services website at**://www.maine.gov/bms/MaineCareBenefitManualRules.htm** or, for a fee, interested parties may request a paper copy of rules by contacting at 207-287-9368. The TDD/TTY number is 1-800-423-4331.

A copy of the public comments and Department responses can be obtained by calling 207-287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 287-3094, or 1-800-321-5557, extension option 9 or TTY: (207)287-1828 or 1-800-423-4331 or e-mail your questions to BMS.inquiry@Maine.gov.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services
Bureau of Medical Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapters II & III, Section 22, Home and Community Benefits for the Physically Disabled

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The adopted rules specify the case management and administrative roles of the provider agency. The adopted rule also clarifies when services are considered to be duplicative, covered services, definitions, and the eligibility process. Certain information, such as confidentiality requirements, that is already included in Chapter I, is deleted. Terminology, such as using MaineCare instead of Medicaid and member instead of recipient, is also updated. Additional changes include revisions to billing procedure codes necessary to update MaineCare billing codes to current coding practice. The Assessing Services Agency will be reimbursed through a separate contract. The Provider/Care Management Agency will now be reimbursed a monthly case management amount.

See http://www.maine.gov/bms/MaineCareBenefitManualRules.htm for rules and related rulemaking documents.

EFFECTIVE DATE: October 31, 2004

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CHAPTER II

HOME AND COMMUNITY BENEFITS FOR THE PHYSICALLY DISABLED

SECTION 22 10/1/86

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CHAPTER II

HOME AND COMMUNITY

SECTION 22 **BENEFITS FOR THE PHYSICALLY DISABLED** 10/1/86

22.01 **PURPOSE**

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The purpose of this benefit is to provide medically necessary home and community benefits to MaineCare members who are physically disabled and age eighteen (18) and over.

22.02 **DEFINITIONS**

22.02-1 Assessing Services Agency (ASA) is the contractor authorized to conduct face-to-face assessments, using the Department of Health and Human Services' (DHHS or the Department) Medical Eligibility Determination (MED) form, and the timeframes and definitions contained therein, to determine medical eligibility for covered services. Based upon a member's assessment outcome scores recorded in the MED form, the ASA is responsible for authorizing a plan of care that shall specify the number of hours for services. The ASA is the Department's contractor for medical eligibility determinations, care plan development, and authorization of covered services under this Section.

22.02-2 Assisted Living Services means the provision of assisted housing services, assisted housing services with the addition of medication administration, or assisted housing services with the addition of medication administration and nursing services, or supported living arrangement certified by DHHS Adult Mental Health Services. Assisted living services are provided by an assisted housing provider, either directly by the provider or indirectly through contracts with persons, entities, or agencies.

22.02-3 Attendant is an individual who meets the qualifications outlined by the member and Provider Agency. The attendant must be certified by the member pursuant to Section 22.09-2(C) and, under the direction of the member, must competently assist in the fulfillment of the personal assistance service needs identified in the member's authorized plan of care.

22.02-4 Authorized Plan of Care is a plan that is determined by the ASA or the Department, and that specifies all services to be delivered to a member as allowed under this Section, including the number of hours for any MaineCare covered services under this Section. The authorized plan of care shall be based upon the member's assessment outcome scores recorded in the Department's Medical Eligibility Determination (MED) form, its definitions, and the time frames on the MED form. The authorized plan of care must be completed on the Department-approved form and must not exceed services required to provide necessary assistance with activities of daily living (ADL), instrumental activities of daily living (IADL) and identified health maintenance activities in the MED form. All authorized covered services provided under this Section must be listed in the care plan summary on the MED form. The authorized plan of care must reflect the needs identified by the assessment, giving consideration to the member's living arrangement, informal supports, and services provided

22.02 **DEFINITIONS** (cont)

Effective 10-31-04 by other public or private funding sources to assure non-duplication of services, including Medicare and MaineCare hospice services. To prevent duplication of services, if the member receives attendant services under this Section and he/she also receives hospice services, then the provider's responsibility is to inform the hospice provider that attendant services are being provided and the number of hours must be identified as a need on the hospice plan of care.

Effective 10-31-04 22.02-5 Case Management Services are covered services under this Section and include the provision of member instruction, the implementing, coordinating, monitoring and reviewing of the services identified and authorized during the eligibility determination process and documented on the care plan summary portion of the MED form. Case management includes face-to-face contact with the member in his or her place of residence, to ensure that the authorized plan of care is implemented, that services are delivered and are appropriate to the member's needs, to monitor the member's health status, and to obtain member feedback. Case management also serves to identify medical, social, educational and other member needs and to facilitate access to needed services. Case management should include monitoring the member's ongoing ability to manage his/her personal attendant and optimal level of independence.

Effective 10-31-04 22.02-6 Consumer Directed Attendant Services, also known as personal care attendant (PCA) Services, or attendant services, enable eligible members with disabilities to re-enter or remain in the community and to maximize their independent living opportunity at home. Consumer directed attendant services include assistance with activities of daily living, instrumental activities of daily living, and health maintenance activities. The eligible member hires his/her own attendant, trains the attendant, supervises the provision of covered services, completes the necessary written documentation, and if necessary, terminates services of the attendant. The Department or the ASA, consistent with these rules, shall determine medical eligibility for services under this Section, prior authorize all covered services, and provide an authorized plan of care for each new and established member.

22.02-7 Covered Services are those services for which payment may be made by the Department under these rules pursuant to Title XIX and XXI.

22.02-8 Extensive Assistance means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three or more times, or
- Full staff performance during part (but not all) of the last seven (7) days.

22.02 **DEFINITIONS** (cont.)

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22.02-9 Family Member is a spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative.

22.02-10 Health Maintenance Activities are activities designed to assist the member with activities of daily living and instrumental activities of daily living, and additional activities specified in this definition. These activities are performed by a designated caregiver for a competent self-directing member who would otherwise perform the activities, if he or she were physically able to do so, to enable the member to live in his or her home and community. These additional activities include, but are not limited to, catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, and occupational and physical therapy activities such as assistance with prescribed exercise regimes.

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22.02-11 Limited Assistance is a term used to describe an individual's self-care performance in activities of daily living, as determined by the Department's approved assessment process. It means, although the individual was highly involved in the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was required and provided:

- Guided maneuvering of limbs or other non-weight-bearing assistance three or more times, or

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- Guided maneuvering of limbs or other non-weight bearing assistance three or more times plus weight-bearing support one or two times.

22.02-12 Medical Eligibility Determination (MED) Form means the form, approved by the Department, for medical eligibility determinations and service authorization for the authorized plan of care based upon assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form are contained therein and provide the basis for services and the plan of care authorized by the ASA. The care plan summary, contained in the MED form, documents the authorized plan of care and to avoid duplication, services provided by other possible public or private program funding sources. It also includes service category, reason codes, duration, unit code, number of units per month, rate per unit, and total cost per month.

22.02-13 Medical Eligibility Determination Packet includes a signed release of information, the completed medical eligibility determination form, the eligibility notification, hearing and appeal rights, the signed Choice letter, MECARE generated care plan that explains benefits of the authorized care plan to the member, transmittal, and contact notes. The service plan and the

22.02 **DEFINITIONS** (cont.)

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transmittal must be submitted to the Department by the Provider Agency within 72 hours of completing skills training and after the member has hired a personal attendant. Service plans and transmittals that do not meet Department specifications and relevant policy will be returned to the Provider Agency by the Department.

22.02-14 Nursing Facility Services are services for medical or nursing care described in Section 67 of the MaineCare Benefits Manual under "Nursing Facility Services." They primarily include professional nursing care or rehabilitative services for injured, disabled, or sick members which are needed on a daily basis and, as a practical matter, can only be provided in a nursing facility, ordered by and provided under the direction of a physician, and are less intensive than hospital inpatient services.

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22.02-15 One-person Physical Assist requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.

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22.02-16 Personal Emergency Response Systems (PERS) is an electronic device that enables certain high-risk members to secure help in the event of an emergency.

22.02-17 Provider/Case Management Agency (also referred to as Provider Agency) is a community-based agency meeting the Independent Living Title 7, Part C standards as defined in the Amendments to the Rehabilitation Act of 1992 as adopted by the National Council on Disabilities. The agency must have the goals of self-determination, self-help, deinstitutionalization and barrier-free access to opportunities and services. The organization must have the

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organizational and administrative capacity to administer and monitor consumer directed attendant services. The agency must sign a Provider/Supplier Agreement with the Department and comply with all terms of this Section, Chapter I, and other applicable Sections (e.g: Section 67) of the MaineCare Benefits Manual. The agency is responsible for a range of activities that include the following: coordinating and overseeing the services in the member's plan of care authorized by the ASA; skills training, ensuring that authorized services are delivered according to the service plan; serving as a resource for members to identify available service options and service providers; answering questions; and assisting with resolving problems around member direction. The agency is also responsible for administrative functions, including: maintaining member records; processing claims; attendant payroll and collecting cost of care, overseeing and assuring compliance with policy requirements and conducting required utilization review activities. For purposes of this Section, the Provider Agency is the Department's authorized agent.

22.02 **DEFINITIONS** (cont.)

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22.02-18 Qualified or Eligible Member, also called the consumer, is the member with a disability who has functional impairments that interfere with self-care and activities of daily living and meets the medical eligibility criteria in Section 22.03. The member must have the cognitive capacity, as measured on the Medical Eligibility Determination form, to competently direct and manage the attendant on the job to assist and/or perform the self-care and daily ADLS, IADLS, and health maintenance activities. The member must be determined eligible for services under this Section.

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22.02.19 Residential care facility means a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services. Residential care facilities provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. "Residential Care facility" does not include a licensed nursing home or a supported living arrangement certified by DHHS Adult Mental Health Services (formerly DBDS) for behavioral and developmental services.

22.02-20 Self Direct means the member trains his/her attendant(s) and directs the provision of attendant services. The member's ability to self-direct must be documented on the MED Form as defined in this Section.

22.02-21 Service Plan is the document used by the Provider/Case Management agency to assist the member to direct his or her attendant to provide services as specified on the authorized plan of care. The service plan must outline the ADL, IADL, and health maintenance tasks, the time authorized to complete the tasks, and the frequency of the tasks that will be the basis for the attendant's job description and weekly schedule. The service plan must reflect the total authorized hours available each week for the member to manage and direct the attendant. The hours must not exceed the hours authorized on the MED form care plan summary and must include only the covered services from Section 22.05. The service plan must not be completed until the MED form is completed, medical eligibility determined, and the number of hours of care are authorized by the ASA as allowed under this Section.

22.02-22 Significant Change means a major change in the member's status that is not self limiting, affects more than one (1) area of functional or health status, and requires a multi-disciplinary review or revision of the authorized plan of care. A significant change assessment is appropriate if there is a consistent pattern of change, with either two (2) or more areas of improvement or decline that affect member needs.

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22.02-23 Total Dependence means full staff performance of the activity during the entire last seven (7) day period across all shifts.

22.03 **ELIGIBILITY FOR SERVICES**

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A. Members must: meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual, be age eighteen (18) or over, and meet the medical requirements, and the other specific requirements of this Section. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I.

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B. Medical eligibility requirements

Applicants shall be assessed using the Department's MED form. An applicant meets the medical eligibility requirements for benefits under this section if he/she meets the eligibility criteria specified in the MaineCare Benefits Manual, Chapter II, Section 67, Nursing Facility Services. The plan of care, authorized by the ASA, must reflect the covered services required and identified by the assessment, giving consideration to the member's living arrangement, informal supports, and services provided by other public and private funding sources. The clinical judgment of the Department's ASA is determinative for the scores on the medical eligibility determination assessment.

A registered nurse trained in conducting assessments with the Department's approved MED form must conduct the medical eligibility assessment. The assessor must consider documentation, perform observations, and conduct interviews with the member, family members, direct care staff, the member's physician(s) and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment.

The member must have the cognitive capacity, as measured on the MED form to be able to "self direct" the attendant. The ASA will assess cognitive capacity as part of each member's eligibility determination using the MED findings. The Provider Agency will assess cognitive capacity as part of member instruction. Minimum MED form scores are:

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(a) decision making skills: a score of 0 or 1;
(b) making self understood: a score of 0, 1, or 2;
(c) ability to understand others: a score of 0, 1, or 2;
(d) self performance of managing finances: a score of 0, 1, or 2; and
(e) support for managing finances: a score of 0, 1, 2, or 3.

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A member not meeting the specific scores detailed above during his or her eligibility determination will be presumed not able to self direct and ineligible for benefits under Section 22.

AND

22.03 **ELIGIBILITY FOR SERVICES** (cont.)

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C. Other Specific Eligibility Requirements

A member must meet all of the following requirements:

1. The member must not have a guardian or a conservator;

2. The monthly projected cost of benefits needed by the member is estimated to be less than 100% of the aggregate average monthly cost of care in a nursing facility per benefit year;

3. A member who meets the eligibility criteria for nursing facility level of care has been informed of, and offered the choice of available, appropriate and cost-effective, home and community benefits;

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4. The member selected benefits as documented by a signed Choice Letter;

5. The health and welfare of the member would not be endangered if the member remained at home or in the community, as determined by the ASA, the Provider/Case Management Agency or the Department;

6. The benefits needed by the member are available (in the geographic area) and a willing provider is available;

7. The member must have a disability with functional impairments, which interfere with his/her own capacity to provide self-care and daily living skills without assistance. The member's disability must be permanent or chronic in nature as verified by the member's physician;

8. The member must agree to complete initial member instruction and testing within thirty (30) days of completion of the MED form to determine medical eligibility in order to develop and verify that he or she has attained the skills needed to hire and train, schedule and supervise attendants, and document the provision of personal care services identified in the ASA's authorized plan of care. Members who do not complete the course of instruction or do not demonstrate to the Provider Agency that they have attained the skills needed to self direct are not eligible for services under this Section;

9. The member must not be residing in a hospital, nursing facility, private non-medical institution, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) as an inpatient;

22.03 **ELIGIBILITY FOR SERVICES** (cont.)

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10. The member must not reside in Assisted Living (as defined in MaineCare Benefits Manual (MBM), Chapters II and III, Section 6,) or in Adult Family Care Home (as defined in MaineCare Benefits Manual, Chapters II and III, Section 2), or other residential setting including a Private Non-Medical Institution (MBM, Chapters II and III, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare).

11. The member must not be receiving personal care services under the Private Duty Nursing/Personal Care Services Section or be receiving any Home and Community Benefits or In Home Community and Support Services for Elderly and Other Adults;

12. Members will be accepted for benefits under this section on a combined priority and first-come, first-served basis. First priority will be given to members who meet the medical eligibility criteria set forth in Section 67.02-3(A), of the MaineCare Benefits Manual. Within this category, members will be served on a first-come, first served basis.

    Second priority will be given to applicants who meet the medical eligibility criteria set forth in Section 67.02-3(B) OR (C). Within this category members will be served on a first-come, first served basis. The Provider/Case Management Agency will maintain member waiting lists; and

13. The member, in addition to meeting all of the above criteria, must hire an attendant. Should the member fail to hire an attendant, expenses for case management shall not be reimbursed by the Department.

22.04 **AMOUNT AND DURATION OF SERVICES**

Each member is eligible for covered services, as identified, documented, and authorized on the MED form subject to the limits in Section 22. The Department or its ASA, consistent with these rules, is responsible for prior authorizing the number of hours of covered services not to exceed the limits in Section 22.06. The Department or the ASA will develop an authorized plan of care for each new member, or established member, as his or her scheduled re-assessment comes due or as the result of a Significant Change. The services provided must be reflected in the service plan and based upon the authorized covered services documented in the care plan summary of the MED form.

MaineCare coverage of services under this Section requires prior authorization from the Department or the ASA, consistent with these rules. Beginning and end dates of a member's medical eligibility period (also known as the classification period) correspond

22.04 **AMOUNT AND DURATION OF SERVICES** (cont)

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to the beginning and end dates for MaineCare coverage for these services. The ADL and IADL Task Time Allowances in the attached Appendix A reflect the time normally allowed to accomplish the listed tasks. The ASA will use these allowances when authorizing a member's authorized plan of care on the care plan summary in the MED form and these allowances will be reflected in the service plan. If these times are not sufficient, when considered in light of a member's unique circumstances, as identified and documented by the ASA, the ASA may make an adjustment as long as authorized hours do not exceed the limits established in Section 22.06.

A. Services under this Section shall be reduced, terminated or denied by the Department, ASA or the Provider/Case Management Agency as appropriate for one or more of the following reasons.

1. The member declines these services;

2. A significant change occurs in the member's medical, functional, or cognitive status and the ASA or Provider/Case Management Agency determines that appropriate services can no longer be provided under this Section;

3. The ASA or the Provider/Case Management Agency determines that the health and welfare of the member is endangered should he or she remain at home receiving services under this Section;

4. The Provider/Case Management Agency documents the member fails to manage an attendant consistent with requirements of this Section;

5. The member enters a hospital, nursing facility, private non-medical institution, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) as an inpatient;

6. The member resides in Assisted Living (as defined in MaineCare Benefits Manual, Chapters II and III, Section 6,) or Adult Family Care Home (as defined in MaineCare Benefits Manual, Chapters II and III, Section 2,) or other residential setting including a Private Non-Medical Institution (MBM, Chapters II and III, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (ie private or MaineCare);

7. The member receives personal care services under the Private Duty Nursing/Personal Care Services or is receiving any Home and Community-Benefits or In-Home Community and Support Services for Elderly and Other Adults;

8. The member does not meet the eligibility criteria in Section 22.03 of the MaineCare Benefits Manual as determined by the ASA or Provider/Case Management Agency;

22.04 **AMOUNT AND DURATION OF SERVICES** (cont)

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9. The member is not financially eligible to receive benefits;

10. When the member's most recent MED assessment and the clinical judgment of the ASA, determine that the authorized plan of care shall be changed or reduced, according to the clinical judgment of the ASA or the Department, and subject to the limitations within this Section. Even though the member's medical eligibility for home and community benefits may not be affected, the plan of care must be modified by the ASA to reflect the changes required;

11. Services have been suspended for more than 30 days. The member's eligibility for these services will be terminated and will require a new assessment by the ASA and prior authorization for services to re-start;

12. The federally approved waiver under which these rules were promulgated expires or a future amendment is not approved;

13. The ASA or Provider/Case Management Agency documents the member does not comply with the authorized plan of care;

14. The member gives fraudulent information to the Department, ASA or Provider/Case Management Agency;

15. The Department, the ASA, or the Provider/Case Management Agency documents that the member or someone living in or visiting the member's residence, harasses, threatens or endangers the safety of the individuals delivering services;

16. The ASA or Provider/Case Management Agency documents the member is directing the personal attendant to complete tasks not included as covered services in Section 22.05;

17. The member fails to pay the cost of care for two (2) months and there is no willing Provider/Case Management Agency available to continue services;

18. Failure of the member to demonstrate the skills necessary to successfully manage his/her personal-health maintenance, including satisfactory management of the PCA, will result in termination of benefits; or

19. The cost of services is likely to exceed the monthly average cap.

Suspension - Services will be suspended if the member is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days, eligibility will be terminated under this section. A new assessment by the ASA and the restart of services will be subject to any wait list for the benefit.

22.04 **AMOUNT AND DURATION OF SERVICES** (cont)

B. Transfer of Waiver Services

Effective 10-31-04

A recipient of Home and Community Benefits for the Physically Disabled may transfer to the Waiver for the Elderly and Adults with Disabilities or any other NF level of care Waiver as may be necessary due to service needs. The Provider Agency shall submit the Department's approved transmittal form to the Department including the member's relevant records covering the last ninety (90) days to the ASA and prepare him/her for the transfer. A medical eligibility assessment is not required as a part of the transfer process unless that assessment is over ninety (90) days old.

22.05 **COVERED SERVICES**

Covered services are available for members meeting the eligibility requirements set forth in Section 22.03. All covered services require prior authorization by the Department, or the ASA, its contractors, consistent with these rules, and are subject to the limits in Section 22.06. Covered services must be required in order to maintain the member's current health status, or prevent or delay deterioration of a member's health and/or avoid long-term institutional care. Services under this Section require prior authorization by the Department or its ASA and are included in the calculation of the member's financial cap and cannot exceed established limits in this Section. Services shall not be reimbursed until both the medical and the financial eligibility have been approved and a personal care attendant has been hired. Members who meet the eligibility requirements for services under this Section are eligible for the following services, as included by the ASA, in the authorized plan of care:

Members who qualify for benefits are eligible for the following services:

A. Case Management activities are guided by the member's authorized plan of care. Case management services include the following functions:

1. Member instruction services, with a minimum of four (4) hours documented initially for instructing the member in the management of personal attendants and additional instruction as required.

   Case managers must instruct each new eligible member prior to the start of services. The provider must document that the member has successfully completed the training within thirty (30) calendar days of the determination of medical eligibility.

   Instruction in PA management includes instruction in recruiting, interviewing, selecting, training, scheduling, and directing a competent attendant in the activities in the authorized plan of care and obligations under this Section.

22.05 **COVERED SERVICES** (cont.)

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The Provider/Case Management Agency may substitute a competency–based assessment in lieu of repeat instruction for members having previously completed such training under an earlier eligibility period.

2. Conducting face-to-face case monitoring with the member at least once every four (4) months or more often as necessary, as in the authorized plan of care by the ASA.

3. Assessing the member/attendant relationship, including whether attendant duties are being performed satisfactorily and, whether attendant training is adequate or if additional training is required and shall arrange for the provision of the additional training.

4. Tracking use of PA hours to assure that the personal care costs during a year do not exceed established limits.

5. Referring members to the ASA for an unscheduled reassessment who have reached the personal care service limit if that limit can no longer assure the health and welfare of the member and ensure that the member receives information and assistance about other options to facilitate transition to another service or institution.

6. Monitoring the member's receipt of services and overall health status.

B. Other tasks required by the Provider/Case Management Agency for overall administration management, paying providers and reporting include:

1. Collecting cost of care payments;

2. Assessing the member-attendant relationship, including whether attendant training is adequate, and taking appropriate action, including referral to Adult Protective Services as appropriate;

3. Documenting and investigating all complaints from any party within two (2) business days, and resolution of all complaints within thirty (30) days;

4. Preparing and distributing attendant payroll, and processing claims for payment;

5. Processing the assessment and other required paperwork;

6. Establishing and maintaining member files in accordance with this Section;

22.05 **COVERED SERVICES** (cont.)

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7. Ensuring implementation of the authorized plan of care;

8. Coordinating and requesting required re-assessments and referrals for unscheduled re-assessments based upon a significant change in the member's health status or change in service needs;

9. Monitoring the services and support and evaluating the effectiveness of the plan with the member;

10. Issuing a "notice of intent to suspend, reduce, deny or terminate home and community benefits" as appropriate when the member is ineligible for these services or the level of services are reduced;

11. Tracking and reporting services delivery; and

12. Providing information as required by the Department.

The costs for the overall administration of this benefit shall be built into the rate for provider/case management services include those services listed in Section 22.05(A & B.)

Transitional case management services may be provided to an individual in the hospital or nursing facility for sixty (60) days prior to de-institutionalization. However, these services cannot be billed until the member has returned to the home or community based setting and a personal care attendant has been hired under this benefit. Case management and instruction may be provided to a member receiving Private Duty Nursing and/or Personal Care Services, under Chapter II, Section 96, until personal care attendant services under this benefit are in place for the member, at which point such services (case management and member instruction) may be billed under this Section.

C. Personal Care Attendant Services (PCA). These services include services related to a member's physical requirements for assistance with the activities of daily living, including assistance with related health maintenance activities.

Additionally, when authorized and specified by the Department or ASA in the authorized plan of care, attendant services may include IADLs and/or health maintenance activities, which are directly related to the member's plan of care. These activities must be performed in conjunction with direct care to the member. IADLs and health maintenance tasks are those that would otherwise be normally performed by the member if he or she were physically able to do so. It must also be established that there is no family member or other person available to assist with these tasks. Travel time is only allowed for an attendant while he/she is in the course of delivering a covered service allowed under this section.

22.05 **COVERED SERVICES** (cont.)

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ADL tasks include assistance with:

1. Bed mobility, transfer, and locomotion activities to get in and out of bed, wheelchair or motor vehicle;
2. Using the toilet and maintaining continence;
3. Health maintenance activities as defined in Section 22.02-11;
4. Bathing, including transfer;
5. Personal hygiene which may include combing hair, brushing teeth, shaving, applying makeup, washing and drying face, hands, and perineum;
6. Dressing;
7. Eating, and clean up; and
8. Assistance with administration of medications as directed by the member for the member.

The ASA will use the allowances in Appendix A to determine the time necessary to complete authorized ADL tasks. If these times are not sufficient when considered in light of a member's unique circumstances as identified and documented by the ASA, the ASA may make an appropriate adjustment subject to the limits in this Section.

Personal attendant IADL services include meal preparation, grocery shopping, routine housework, and laundry, which are directly related to the member's plan of care. Household tasks must be authorized and specified in the authorized plan of care. These tasks must be furnished in conjunction with direct care to the member and directed by the member.

IADL tasks include assistance with:

1. grocery and prepared food shopping, assistance with obtaining medication, to meet the member's health and nutritional needs;

2. routine housework, including sweeping, washing and/or vacuuming of floors, cleaning of plumbing fixtures (toilet, tub, sink), appliance care, changing of linens, refuse removal;

3. laundry done within the residence or outside of the home at a laundry facility;

4. money management, as directed by the member for the member; and

5. meal preparation and clean up.

D. Personal Emergency Response System (PERS) is limited to the monthly phone charge for the emergency response system and the home unit communicator for members residing in areas where this system is available.

22.06 **LIMITS**

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A. MaineCare will reimburse for no more than eighty-six and one-quarter (86.25) hours of personal attendant services per week under this Section.

B. If the member is enrolled in a hospice and if there is any duplication between the two services as identified by the ASA and determined by the Department, then certified nursing assistant or home health aide hours provided through the hospice will count toward the member's authorized hours under this Section.

22.07 **NON-COVERED SERVICES:**

The following services are non-covered services:

A. Room and board;

B. Travel time and mileage by the ASA, Provider/Case Management Agency's staff, and/or the attendant to and from the location of the member's residence or mileage for travel by the attendant in the course of delivering a covered service;

C. Transportation to and from medical appointments is not covered under this Section and must be referred to a local MaineCare transportation agency (see Chapters II and III, Section 113 of the MaineCare Benefits Manual);

D. Household tasks except when delivered as an integral part of the authorized plan of care;

E. Services provided by the member's family member, as defined in Section 22.02-9

F. Custodial care or respite care;

G. Personal attendant services received when a member enters a hospital, nursing facility, private non-medical institution, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) as an inpatient;

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H. The member is residing in Assisted Living (as defined in MaineCare Benefits Manual, Chapters II and III, Section 6,) or Adult Family Care Home (as defined in MaineCare Benefits Manual, Chapters II and III, Section 2,) or other residential setting including a Private Non-Medical Institution (MBM, Chapters II and III, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare).

I. The member is receiving personal care services under the Private Duty Nursing/Personal Care Services or any Home and Community Benefits or In-Home Community and Support Services for Elderly and Other Adults;

22.07 **NON-COVERED SERVICES** (cont.)

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J. Other services described as non-covered in Chapter I of the MaineCare Benefits Manual;

K. Services provided by an attendant who has a notation on the Maine Registry of Certified Nursing Assistants of (a) any criminal convictions, except for Class D and Class E convictions over ten (10) years old that did not involve as a victim of the act, a patient, client, or resident of a health care entity; or (b) any specific documented findings by the State survey agency of abuse, neglect or misappropriation of property of a resident, client or patient;

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L. Services provided outside the presence of the member; unless in the provision of covered IADLs;

M. Services offered under this benefit will exclude expenses for transportation and recreational or leisure activities, as well as, the actual time involved in transporting the member to recreational or leisure activities;

N. On-call services;

O. Services that exceed the limits described in this Section;

P. Separate billings for the time spent performing separate administrative tasks are not covered. (Examples of tasks not separately billable include claim preparation and submission, personnel time other than the case manager's, travel time to and from the member’s residence, record keeping); and

Q. Expenses for case management are non-reimbursable if the member fails to hire an Attendant.

22.08 **ELIGIBILITY PROCESS**

Applicants for services under this Section must meet the eligibility requirements set forth in Section 22.03. An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department or the ASA.

These services require eligibility determination and prior authorization by the ASA.

The Department, or its ASA, shall conduct a medical eligibility assessment using the Department's approved MED form. The individual conducting the assessment shall be a registered nurse (RN) and will be trained in conducting assessments and developing an authorized plan of care with the MED. The RN assessor’s findings and scores recorded in the MED form shall be determinative in establishing eligibility for services and the authorized plan of care.

The anticipated costs of services under this Section to be provided under the authorized plan of care must conform to the limits set forth in Section 22.06.

22.08 **ELIGIBILITY PROCESS** (cont)

Effective 10-31-04

A. Eligibility Determination

Step #1: A complete, standardized referral, or verbal/written request by the member, or Provider/Case Management Agency for a medical eligibility assessment shall be submitted to the ASA or the Department. The Bureau of Family Independence may also submit a request to the ASA for determination of medical eligibility. The ASA shall conduct a medical eligibility assessment within five (5) calendar days of receipt of a complete request, except when the member is receiving acute level of care services. In such cases, the assessment is delayed until twenty-four (24) hours after discharge, or when continued acute level services are denied.

Step #2: Financial eligibility is determined by the local office of the Bureau of Family Independence. If financial eligibility for MaineCare has not been determined, the applicant must be referred to the regional office of the Bureau of Family Independence, concurrent with the relevant medical eligibility determination process. The ASA's pre-screen intake process may instruct the applicant and/or designated representative to initiate the financial eligibility process at the local office of the Bureau of Family Independence. For SSI members, no financial determination process is necessary. The RN assessor will verify SSI status. When these benefit funds are not available, the ASA will discuss other funding service options during the assessment process. The ASA will initiate any necessary referrals on the member's behalf to access home care options. The member will be informed that his or her name has been referred to a waiting list, when applicable.

Step #3: The Department, or its ASA, conducts a face-to-face medical eligibility assessment using the MED. The individual conducting the assessment must be a registered nurse and will be trained in conducting assessments and developing an authorized plan of care with the MED. The RN assessor's findings and scores recorded in the MED form shall be determinative in establishing eligibility for services and the authorized plan of care.

The anticipated costs of services under this Section to be provided under the authorized plan of care must conform to the limits set forth in Section 22.06.

22.08 **ELIGIBILITY PROCESS** (cont.)

Effective 10-31-04

B. Eligibility Procedure

Applicants who meet the eligibility criteria set forth in Section 22.03, and as documented on the MED form, shall:

1. receive an authorized plan of care based upon the scores, timeframes and findings recorded in the MED level of care for which they are eligible. The covered services to be provided in accordance with the authorized plan of care: 1) shall not exceed the established service limits and financial caps; 2) must be prior authorized by the Department or the ASA.

2. inform the member, of the options stated in the Choice Letter. The member will need to indicate his or her choice of either nursing facility services or home and community benefits on the Choice Letter and state his or her wish to initiate services by signing the Choice Letter. If the financial eligibility process has not been initiated, the ASA assessor will provide an application for financial eligibility determination and refer the applicant to the Bureau of Family Independence. The RN assessor shall approve an initial classification period for up to six months, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment.

3. The ASA shall forward the completed assessment packet to the Department's Provider/Case Management Agency within seventy-two (72) hours of the medical eligibility determination and development of the authorized plan of care.

4. On receipt of the eligibility packet the Provider/Case Management Agency shall:

   a. contact the member within twenty-four (24) hours;

   b. initiate member instruction. The Provider Agency will complete initial instruction within thirty (30) days of the completion of the MED form. The Provider Agency will notify the Department, using the transmittal form approved by the Department, when the member has successfully completed this requirement, and an attendant has been hired. Payment of benefits under this Section can begin only after the Department is notified that the member has successfully completed this training, an attendant has been hired and the transmittal and service plan have been submitted to the Department;

   c. the Provider Agency will request written verification from the member's physician that the disability is permanent or chronic in nature;

22.08 **ELIGIBILITY PROCESS** (cont.)

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d. the service plan will be completed following the authorized plan of care on the care plan summary on the MED form;

e. monitor service utilization and refer for an unscheduled reassessment thirty (30) days prior to the member reaching the limit for personal care services; and

f. assure compliance with rules of this section each month.

C. Reclassification and Continued Services

1. For all members receiving services under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted no later than the reclassification date. Members receiving service under this Section shall be assessed for continued medical eligibility for services, face-to-face, with the member, at the member's residence, at least every six (6) months during the first year the member receives services under this Section and then at least annually. An unscheduled reassessment must be requested, if a Significant Change occurs or the member reaches the personal care service limit established in Section 22.06 and that limit can no longer assure the health and welfare of the member. The unscheduled reassessment will ensure that the member receives information and assistance about other options to facilitate transition to another service or institution. MaineCare payment ends with the reassessment date, also known as the classification end date.

2. The Provider Agency must submit a reassessment request to the ASA. The ASA must complete a reassessment at least five (5) calendar days prior to the end date of the member's current medical eligibility period to establish continued eligibility for MaineCare coverage of attendant services. If the need for additional skills instruction has been identified by the ASA or the Provider Agency, it will be documented in the member's service plan.

3. The Provider Agency will provide relevant information to the ASA, including any findings from the face-to-face care management and any concerns around consumer direction or management of the member's PCA. The information shall be shared with the ASA as part of the referral for re-determination of medical eligibility and development of the authorized plan of care.

4. The ASA will follow the steps in Section 22.08 and assign a reclassification date based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment. A Choice Letter must be signed annually.

22.08 **ELIGIBILITY PROCESS** (cont.)

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5. Reimbursement of case management and attendant services can begin only after the Department has received the totally completed assessment and other required documents within seventy-two (72) hours of completion of the reassessment visit, according to Department specifications and an attendant has been hired.

6. Ongoing monitoring shall be conducted by the Department of Health and Human Services, Bureau of Elder and Adult Services (BEAS), which will include on-site visits to the ASA and the Provider Agency and visits to a sample of members. The Department will monitor the ASA's and Provider Agency's compliance with the Waiver document, regulations and contract performance.

D. General Procedures

1. The Provider/Case Management Agency shall submit the completed Transmittal form, according to Department procedures and contract parameters. The actual start date of case management and personal care attendant authorized services must be included. When the services are denied or terminated the transmittal must be submitted to the Department within seventy-two (72) hours of the event.

2. The Bureau of Family Independence will notify the individual member that the member is both medically and financially eligible as of approved dates, or BFI may notify the member that the member is medically eligible but financially ineligible.

3. If the Department, or the ASA, determines that the member is ineligible under these rules, the Department or ASA will inform the Bureau of Family Independence of medical ineligibility.

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4. If the member chooses nursing facility care, the member will be placed in accordance with existing placement procedures as set forth in the MaineCare Benefits Manual, Chapter II, Section 67. In the event a nursing facility bed is not available, the member may choose home and community benefits within 30 days of the assessment date. A new Choice Letter must be signed.

5. If the member is found to be ineligible under these rules, the member shall be informed of his/her right to request an administrative hearing before the Department in accordance with Chapter I of the MaineCare Benefits Manual under the Section Member Appeals.

22.09 POLICIES AND PROCEDURES

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22.09-1 Member Complaint Logs

The ASA and Provider/Case Management Agency must maintain a log of member complaints regarding home and community benefits, which includes all verbal and written complaints. The log must contain documentation regarding the member, date and nature of the complaint and how each complaint was addressed or resolved. The member complaint log must be made available to the Department upon request.

22.09-2 Professional and Other Qualified Staff

The following professionals are qualified professional staff:

A. Eligibility determination staff must be a registered nurse licensed to practice nursing in the State of Maine.

B. Case Management and Consumer Instruction staff include:

1. A registered nurse licensed to practice nursing in the State of Maine;

2. A registered occupational therapist who is licensed to practice occupational therapy in the State of Maine;

3. A certified occupational therapy assistant who is licensed to practice occupational therapy in the State of Maine, under the documented supervision of a licensed occupational therapist; and

4. A peer instructor is an employee of the provider/case management agency who can teach the skills required for a member to successfully utilize a self-directed PCA system including: recruiting, interviewing, selecting, training, scheduling and supervising a competent PCA.

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C. Attendant

An attendant must be at least seventeen (17) years old and have the ability to assist with activities of daily living. An attendant cannot be an individual who has a notation on the Maine Registry of Certified Nursing Assistants of (a) any criminal convictions, except for Class D and Class E convictions over ten (10) years old that did not involve as a victim of the act, a patient, client, or resident of a health care entity; or (b) any specific documented findings by the State Survey Agency of abuse, neglect or misappropriation of property of a resident, client or patient.

22.09 **POLICIES AND PROCEDURES** (cont)

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After the completion of member instruction, the member shall train the attendant on the job. Within a twenty-one (21) day probation period, the member will determine the competency of the attendant on the job. At a minimum, based upon the attendant's job performance, the member will certify competence in the following areas:

- ability to follow oral or signed and written instructions and carry out tasks as directed by the member;
- disability awareness;
- use of adaptive and mobility equipment;
- transfers and mobility; and

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- ability to assist with health maintenance activities.

Satisfactory performance in the areas above will result in a statement of attendant competency for each attendant. This statement must be completed on a Department-approved form signed by the member, submitted to the Provider/Case Management Agency, with a copy kept in the member's record.

22.09-3 Member Appeals

The Department, the ASA, or the Provider/Case Management Agency must notify the member in writing that he/she has the right to appeal when there has been a denial, termination, suspension or reduction of eligibility for a MaineCare covered service under this Section. In order for services to continue during the appeal process, a request for an appeal must be received by the Department within ten (10) days of the notice to reduce, deny, suspend, or terminate services. Otherwise, a member has sixty (60) days from the date of the notice in which to appeal a decision. Members shall be informed in writing by the ASA or the Provider/Case Management Agency of their right to request an administrative hearing in accordance with this Section and Chapter I of the MaineCare Benefits Manual. The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling 1-800-262-2232 or Local 207-287-9200, or TTY: Toll Free 1-888-720-1925, or TTY: Local 207-287-9234.

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Bureau of Elder and Adult Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

22.09 **POLICIES AND PROCEDURES** (cont)

22.09-4 Records

A. ASA Records

There shall be a specific ASA record for each member, which shall include the following:

1. Member's name, address, phone number, emergency contact, date of birth, MaineCare number;

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2. The referral request, member's release of information, copies of the eligibility determination notices, and Choice Letter;

3. Documentation of all complaints, by any party including resolution action taken;

4. The MED form including the care plan summary/authorized plan of care.

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The care plan summary of the MED form must identify the types and service delivery levels of all other home care services to be provided to the member whether or not the services are reimbursable by MaineCare or under this Section.

B. Provider/Case Management Agency Records

The Provider/Case Management Agency must establish and maintain a record for each member that includes all items in Section 22.09-4 and all items below:

(1) documentation of all contacts between the Provider Agency and the member or ASA;
(2) documentation of all contacts between the member and the attendant, including date, services covered, type of contact, and duration; a daily task list of covered services is acceptable, providing it matches the authorized plan of care (Section 7 of the MED form);
(3) time sheets, which must be signed by the member or the member's agent pursuant to a power of attorney; provided, however, that an agent may not sign on behalf of the member if the agent is the attendant who provided the services pursuant to this section;
(4) documentation of the results of member instruction and testing;
(5) documentation of assessments and reassessments;
(6) complete MED packets;

22.09 **POLICIES AND PROCEDURES** (cont)

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(7) documentation of ability to self direct, as documented on the MED form and as required in member instruction and testing;

(8) signed certification(s) of attendant competency on a Department approved form;

(9) a signed release of information;

(10) attendant payroll records and employment forms;

(11) verification from the member's physician that the disability is permanent or chronic in nature;

(12) documentation of the entrance and exit times for the personal care attendant and for member instruction staff (travel time to and from the location of the member is not covered.);

(13) documentation of all complaints, by any party, including resolution action taken; and

(14) the Service Plan which must indicate the type of services to be provided for each ADL and IADL identified in the MED form, specify the number of hours per week, the tasks, reasons for the service and must be completed after determination of medical eligibility and authorization on the care plan summary of the MED form.

Member records shall be kept current, available to the Department and retained in conformance with Chapter I. Such records must be documentation of services included on invoices.

22.09-5 Surveillance and Utilization Review

Requirements of Surveillance and Utilization Review are detailed in Chapter I of the MaineCare Benefits Manual.

22.10 **REIMBURSEMENT**

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Reimbursement for covered services shall be the lower of the following:

1. The amount listed in Chapter III, Section 22, "Allowances for Home and Community Benefits for the Physically Disabled;" or

2. The lowest amount listed by Medicare.

In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other sources that are available for payment of the rendered services prior to billing MaineCare.

Reimbursement under this Section is subject to the unit rounding requirements and other reimbursement requirements as described in Chapter I of the MaineCare Benefits Manual.

22.11 **PROVIDER AGENCY RESPONSIBILITIES**

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Costs of the overall administration of this service are built into the monthly rate for services. Case management services include Section 22.05(B). Provider tasks include:

1. identifying the need for additional non-scheduled reassessments or additional instruction;

2. providing member instruction and testing that meets the following criteria:

   a. providing at least four (4) hours of instruction initially in the management of personal attendants and additional instruction as needed;

   b. instruction must be provided to each new eligible member prior to the start of services. The Provider Agency must document that the member has successfully completed the training within thirty (30) calendar days of the determination of medical eligibility and successfully passed a test;

   c. instruction in PCA management includes: instruction in recruiting, interviewing, selecting, training, scheduling and supervising a competent attendant in the activities identified in the authorized plan of care and as necessary, terminating an attendant; and

   d. instructing the member in his or her rights and responsibilities, including the obligations under this Section;

3. monitoring, through face-to-face contact at least every four (4) months, documenting and taking appropriate action concerning any changes in the general health and welfare of the member;

4. assessing the member/attendant relationship, including whether attendant duties are being performed satisfactorily, whether attendant training is adequate or if additional training is needed;

5. taking appropriate action, including reporting to the Department, any evidence of public nuisance, substance abuse, harassment, neglect, exploitation, or fraud on the part of the attendant, member, member's household or visitor;

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6. documenting, investigating all complaints from any party within two (2) business days and resolving all complaints within thirty (30) days;

7. establishing and maintaining member files in accordance with this Section;

8. processing claims for payment;

9. preparing information as required by the Department on payment for specific services and beneficiary status;

22.11 **PROVIDER AGENCY RESPONSIBILITIES** (cont)

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10. preparing and distributing attendant payroll;

11. collecting member cost of care amounts; and

12. maintaining a complaint log.

22.12 **BILLING INSTRUCTIONS**

The Provider Agency must bill in accordance with the Department's billing instructions for the HCFA 1500 that providers receive in their enrollment packages.

CHAPTER II

HOME AND COMMUNITY

SECTION 22 **BENEFITS FOR THE PHYSICALLY DISABLED** 10/1/86

APPENDIX A: TASK TIME ALLOWANCES

ADL = Activities of Daily Living				
Activity	**Definitions**	**Time Estimates**		**Considerations**
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed.	5 – 10 minutes		Positioning supports, cognition, pain, disability level.
Transfer	How person moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet).	5 – 10 minutes up to 15 minutes		Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, mechanical lift transfer.
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair.	5 - 15 minutes (Document time and number of times done during Plan of Care)		Disability level, type of aids used, pain.
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis.	20 - 45 minutes		Supervision, disability, cognition, pain, type of clothing, type of prosthesis.
Eating	How person eats and drinks (regardless of skill)	5 minutes		Set up, cut food and place utensils.
		30 minutes		Individual is fed.
		30 minutes		Supervision of activity due to swallowing, chewing, cognition issues.
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes.	5 -15 minutes/use		Bowel, bladder program ostomy regimen, catheter regimen.
Personal Hygiene	How person maintains personal hygiene. (EXCLUDE baths and showers)	20 min/day		Disability level, pain, cognition, adaptive equipment.
	Washing face, hands, perineum, combing hair, shaving and brushing teeth	Shampoo (only if done separately)	15 min up to 3 times/week	
		Nail Care	20 min/week	
Walking	How person walks for exercise only How person walks around own room How person walks within home How person walks outside	Document time and number of times in Plan of Care, and level of assistance needed.		Disability, pain, mode of ambulation (cane), prosthesis needed for walking.
Bathing	How person takes full-body bath/shower, sponge bath (EXCLUDE washing of back, hair), and transfers in/out of tub/shower	15 - 30 minutes		If shower used and shampoo done, then consider as part of activity.

CHAPTER II

HOME AND COMMUNITY

SECTION 22 BENEFITS FOR THE PHYSICALLY DISABLED

10/1/86

IADL = Instrumental Activities of Daily Living			
Activity	**Definitions**	**Time Estimates**	**Considerations**
Light meal, lunch & snacks	Preparation and clean up	5 – 20 minutes	Consumer participation, type of food preparation, number of meals in POC and preparation for more than one meal.
Main Meal Preparation	Preparation and clean up of main meal	20 - 40 minutes	Is Meals on Wheels being used? Preparation time for more than one meal and consumer participation.
Telephone	Used telephone as necessary, e.g., able to contact people in an emergency.	5 minutes	Disability level, type of phone, emergency response system in place.
Light Housework/ Routine Housework	Dusting, picking up living space	30 min – 1.5 hr/week	Size of environment, consumer needs and participation, others in household.
	Kitchen housework-groceries away, general cleaning		
	Making/changing beds		
	Total floor care all rooms and bathrooms		
	Garbage/trash disposal		
	Non routine tasks, outside chores, seasonal		
Managing finances	Managed own finances, including banking, handling checkbook and paying bills.	15 - 30 minutes/week	Consumer participation, paper work, banking, bill paying with other activities, e.g., grocery shopping and laundry.
Grocery Shopping	Preparation of list and purchasing of goods.	45 min - 2 hours/week	Other errands including bills, banking, and pharmacy, distance from home.
Laundry	Sort laundry, wash, dry, fold and put away.	In-home 30 minutes/load 2 loads/week.	Other activities which can be done if laundry is done in the house or apartment. Incontinence may increase time estimate.
		Out of home 2 hours/week	

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These allowances reflect the time normally allowed to accomplish the listed tasks. The ASA will use these allowances when authorizing a member's authorized plan of care. If these times are not sufficient when considered in light of a member's unique circumstances as identified by the ASA, the ASA may make an adjustment as long as the authorized hours do not exceed limits established for member's level of care.

Time authorized has to reflect the possibility of concurrent performance of activities, ex: while wash cycle running, dishes may be washed, floor vacuumed, bathroom cleaned, and other simultaneous activities.

SECTION 22 **HOME AND COMMUNITY BENEFITS FOR THE PHYSICALLY DISABLED** **10/1/86**

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PROC CODE	DESCRIPTION	UNIT	MAXIMUM ALLOWANCE
T2022	Case Management	Month	$126.25 Per Month
S5125	Attendant Care Services	15 Minutes	$2.28 Per 15 Minutes
S5161	Emergency Response System	Month	$35.00 Per Month